MEDICARE

Coverage of Kidney Dialysis and Kidney Transplant Services

A Supplement to the Medicare Handbook

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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MEDICARE AND TREATMENT FOR PERMANENT KIDNEY FAILURE

This supplement to *The Medicare Handbook* explains the special rules that apply to Medicare coverage and payment for kidney dialysis and transplant services.

Medicare also helps pay for a wide range of other health services and supplies. *The Medicare Handbook* describes the other health services and supplies that are covered by Medicare and how payments are made. If you don't have a copy of the *Handbook*, you can get one from Social Security.

THE TWO PARTS OF MEDICARE

Medicare has two parts—hospital insurance (Part A) and medical insurance (Part B). This section briefly describes each part. For more detailed information, see *The Medicare Handbook.*

HOSPITAL INSURANCE (PART A)

Hospital care: Medicare Part A covers medically necessary inpatient hospital care. Part A, for example, helps pay for an inpatient stay in an approved hospital for kidney transplant surgery.

Medicare helps pay for up to 90 days of medically necessary inpatient hospital care in each benefit period. Medicare will help pay for more days if you use all or some of your lifetime reserve days. (See below for an explanation of benefit periods and lifetime reserve days.)

During 1991, from the first day through the 60th day in a hospital during each benefit period, Part A pays for all covered services except the first $628. This is called the Part A deductible. From the 61st through the 90th day in a hospital during each benefit period, Part A pays for all covered services except for $157 a day. This daily amount is called Part A coinsurance. If you need to stay in the hospital longer than 90 days, you may choose to use reserve days.

Skilled nursing facility care: Under certain conditions, Medicare Part A helps pay for 100 days of post-hospital care in a skilled nursing facility per benefit period. No deductible is required and you pay no coinsurance for the first 20 days. In 1991, you pay $78.50 each day for the 21st through the 100th day of care.

Home health care: Medicare Part A helps pay for medically necessary home health care. There is no deductible for Medicare-covered home health care. You pay no home health care coinsurance, except for 20 percent of the approved amount for durable medical equipment.

Hospice care: Medicare Part A helps pay for up to 210 days of hospice care. When necessary, an extended period of coverage may be allowed. You pay no deductible; you pay a small coinsurance amount for outpatient drugs and respite care.

Medicare payments: Medicare payments for services covered by Part A are made directly to the participating hospital, skilled nursing facility, home health agency, and hospice.

Benefit periods: The benefit period is a way of measuring your use of inpatient hospital and skilled nursing facility services under Medicare Part A.

Your first benefit period starts the first time you enter a hospital after your hospital insurance begins. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). If you remain in a facility (other than a hospital) that primarily provides skilled nursing or rehabilitative services, a benefit period ends when you have not received any skilled care there for 60 days in a row.

There is no limit to the number of benefit periods you can have for hospital and skilled nursing facility care.

Reserve days: Medicare Part A includes an extra 60 hospital days you can use if you have a long illness and have to stay in the hospital for more than 90 days. These extra days are called reserve days. During 1991, Part A pays for all covered services except $314 a day for each reserve day you use. You have only 60 reserve days in your lifetime, and you can decide when you want to use them.

MEDICAL INSURANCE (PART B)

Medicare Part B covers doctors services, outpatient hospital services, outpatient physical therapy and speech pathology services, and many other health services and supplies.

Most of the services and supplies needed by people with permanent kidney failure are covered by Part B. For example, Part B covers outpatient maintenance dialysis, staff-assisted dialysis, self-dialysis training, and home dialysis.

If you became entitled to Medicare before you developed permanent kidney failure and have not signed up for Part B or if your Part B has stopped, you can apply for this protection now. If you already have Part B but are paying a premium penalty for late enrollment, your premium amount can be reduced to the current basic rate. Get in touch with Social Security for more information.

After you have paid $100 in Medicare-approved charges for covered medical expenses in 1991, Part B generally will pay 80 percent of the approved charges for any additional covered services you receive during the rest of the year. You are responsible for the remaining 20 percent.

The first $100 in covered expenses is called the Part B deductible. You need to meet this $100 deductible only once during the year. The deductible can be met by any combination of covered expenses. You do not have to meet a separate deductible for each different kind of covered service you receive.

The deductible applies to your expenses for doctors, providers and suppliers. Suppliers are people or organizations other than doctors or health care facilities that furnish equipment or services covered by Part B.

WHEN MEDICARE PROTECTION BEGINS

When you become entitled to Medicare because of permanent kidney failure, your Medicare protection starts with the 3rd month after the month your course of maintenance dialysis treatments began. For example, if you began receiving maintenance dialysis treatments in July, your Medicare coverage would start on October 1.

There are two ways your Medicare protection can begin earlier.

- Medicare coverage can begin in the *first month* of dialysis if:
  - — you participate in a self-dialysis training program in a Medicare-approved training facility,
  - — if you start the training before the third month after dialysis begins, *and*
  - — you expect to complete the training and self-dialyze thereafter.
- Medicare coverage can begin *the month you are admitted* to an approved hospital for a kidney transplant or procedures preliminary to a transplant *if*:
  - — the transplant takes place in that month or within the two following months.

If your transplant is delayed more than two months after you are admitted to the hospital for the transplant or procedures preliminary to the transplant, Medicare will begin two months before the month of the transplant.

WHEN MEDICARE PROTECTION ENDS

If you are entitled to Medicare **only** because of permanent kidney failure, Medicare protection will end 12 months after the month you no longer require maintenance dialysis treatments or 36 months after the month of a kidney transplant. But, if the transplant fails during or after that 36-month period and you again resume maintenance dialysis or receive another transplant, Medicare coverage will continue or be reinstated immediately without any waiting period.

Your Medicare Part B can stop at any time if you fail to pay premiums or if you decide to cancel it.

MEDICARE PAYMENT FOR BENEFICIARIES COVERED BY EMPLOYER GROUP HEALTH PLANS

Some Medicare beneficiaries are also covered by an employer group health plan. For these Medicare beneficiaries the employer plan is often the primary plan—that is, the employer plan pays first on the Medicare beneficiary's health insurance claims.

If you become eligible for Medicare **only** because of permanent kidney failure and are

covered by an employer group health plan, Medicare will be your secondary payer during an initial period of up to 18 months. The 18-month period in which Medicare may be secondary begins the first month you are eligible for Medicare.

NOTE: The 18-month period begins with your **eligibility** for Medicare, whether or not you are entitled. (Entitled means enrolled.)

Since Medicare eligibility usually begins with the third month after the month in which you start a regular course of dialysis, you would have only your employer group health plan coverage during the first 3 months of dialysis. However, if you undertake a course in self-dialysis training or receive a kidney transplant during the 3-month waiting period, part or all of this initial 3-month period would be included in the 18-month period during which Medicare may be secondary.

Employer plans pay first for kidney treatment and other health services furnished during the 18-month period. However, if the employer plan doesn't pay in full, Medicare may make secondary payments to supplement the amount paid by the employer plan. At the end of the 18-month period, Medicare becomes the primary payer. If you are covered by an employer group health plan during the 18-month period, you should tell the person who furnishes you with medical services so that the services can be billed correctly.

If you have more than one period of Medicare entitlement based on kidney disease, there is a separate coordination period for each period of Medicare entitlement. For instance, if you receive a kidney transplant which is successful for at least 36 months, your Medicare protection ends as indicated above under *When Medicare Protection Ends*. If after the 36-month period you file for and again become entitled to Medicare because you resume maintenance dialysis or receive another transplant, your Medicare coverage will be reinstated immediately, without a waiting period, and there will be a new 18-month coordination period if you are covered by an employer group health plan.

WHO CAN PROVIDE MAINTENANCE DIALYSIS AND TRANSPLANT SURGERY

To receive Medicare payments, medical facilities must be specifically approved to provide maintenance dialysis or kidney transplant surgery—even if they already participate in Medicare to provide other health care services covered by the program.

They must meet special health, safety, professional, staffing, and minimum use standards directly related to dialysis and kidney transplant services. And, they must meet federal, state, and local requirements for medical facility planning.

Your doctor or the facility can tell you whether a facility is approved by Medicare for payment of dialysis and transplant services.

COVERAGE OF MAINTENANCE DIALYSIS

This section explains coverage and payment for outpatient maintenance dialysis and the conditions under which inpatient dialysis is covered.

OUTPATIENT DIALYSIS

Medicare Part B helps pay for outpatient maintenance dialysis treatments in any approved dialysis facility. Your coverage includes the costs of laboratory tests, equipment, supplies, and other services associated with your treatment. Part B payments for outpatient maintenance dialysis furnished in the facility are always made to the facility.

Medicare pays the facility based on a per treatment rate that is set in advance. This rate is the facility's **composite rate**. The facility may charge you only 20 percent of this rate. For example, if you have already met the $100 deductible and the composite rate is $130 per treatment, Part B pays the facility 80 percent of $130 (or $104). Medicare *cannot* pay the remaining 20 percent of the charge (or $26). You are responsible for the 20 percent coinsurance charge.

Occasionally, maintenance peritoneal dialysis treatments extend overnight. These extended peritoneal treatments are covered as outpatient services by Part B.

Many of the laboratory tests you receive may be included as part of the facility's maintenance dialysis services. But, if you need additional tests, they can be covered as independent laboratory services, or as outpatient hospital services. For more information, see the sections on doctors services, outpatient hospital services, and other services and supplies in *The Medicare Handbook.*

INPATIENT DIALYSIS

Generally, maintenance dialysis treatments are covered on an outpatient basis. But if you are admitted to a hospital because your medical condition requires the availability of other specialized hospital services on an inpatient basis, your maintenance dialysis treatments would be covered by Part A as part of the costs of your covered inpatient hospital stay. Please see *The Medicare Handbook* for a more information about the coverage of inpatient hospital care.

DOCTORS SERVICES AND MAINTENANCE DIALYSIS

Doctors services are covered by Medicare Part B. While you are on maintenance dialysis, Part B can pay for your doctors services in the following ways.

OUTPATIENT MAINTENANCE DIALYSIS

Medicare pays benefits for all doctors services related to outpatient maintenance dialysis. The Medicare carrier pays for those services through a monthly per-person payment. The same monthly amount is paid for each patient the doctor supervises, regardless of whether the patient dialyzes at home or as an outpatient in an end-stage renal disease (ESRD) facility. Using this method of physician payment, Part B pays 80 percent of the monthly fee, minus any part of $100 deductible you have not met. If your doctor accepts assignment, Medicare payment is made directly to him or her; otherwise, you receive the payment.

All services from your doctor that are provided at the time of treatment of your kidney condition are included in the monthly payment. For example, during a visit to your doctor for your kidney condition, you might receive services for bronchitis. All of the services you receive during this visit would be included in the monthly payment. But, any additional visits for follow-up care of the bronchitis would not be included in the monthly payment. Part B can help pay for additional services of this kind as explained in *The Medicare Handbook.*

INPATIENT MAINTENANCE DIALYSIS

If you are hospitalized, your doctor has a choice of two methods of payment for furnishing services to you as an inpatient. Your doctor may choose to continue to receive the monthly payment, in which case you cannot be billed for any additional amounts. Or, your doctor can choose to bill separately for the inpatient services, which Medicare will pay for in the manner described in *The Medicare Handbook.* In this case, your doctor's monthly payment will be reduced based on the number of days you are hospitalized.

SELF-DIALYSIS TRAINING

Self-dialysis training is covered by Medicare Part B on an outpatient basis.

Coverage of self-dialysis training includes your instruction and instruction for the person who will assist you with maintenance self-dialysis at home. Part B also covers the maintenance dialysis treatment and laboratory tests and other services and supplies associated with the treatment.

By law, Medicare *cannot* cover the cost of paid dialysis aides to assist self-dialysis patients at home. Nor can Medicare cover the costs of transportation to and from the outpatient dialysis center, wages that you and your assistant lose while being trained, or the cost of lodging during treatment.

Payment rates for self-dialysis training sessions are higher than those for maintenance dialysis treatments. And charges vary from one dialysis facility to another, depending upon type of facility and its geographic location. But regardless of variations in charges, this is how Medicare payment works: If you are charged $150 per session and have already met the annual deductible, Part B will pay 80 percent of the training rate (or $120 per session). Medicare *cannot* pay the remaining 20 percent (or $30 per session).

For the services of the doctor who is conducting your self-dialysis training, the

maximum total charge Part B will approve is $500. If your doctor charges $500, Part B would pay 80 percent of $500 (or $400) if you have already met the deductible. Medicare *cannot* pay the remaining 20 percent (or $100), or any charges above the Medicare approved amount.

Retraining for self-dialysis—for example, in the use of new equipment—is also covered by Medicare Part B on an outpatient basis.

HOME DIALYSIS

Medicare Part B covers home dialysis equipment, all necessary supplies, and a wide range of home support services. Home dialysis includes home hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD).

Usually, drugs used in your home are not covered unless a doctor administers them. However, certain drugs for home dialysis patients are covered even though a doctor is not present. The most common of these are heparin, the antidote for heparin when medically indicated, and topical anesthetics. Blood or packed red blood cells *cannot* be covered for home dialysis unless your doctor administers it or personally directs its administration, or if the blood is needed to prime your dialysis equipment (see How Medicare Pays for Blood, page 7).

PAYMENT OPTIONS UNDER HOME DIALYSIS

If you dialyze at home, you can choose between two payment options: *Method I or Method II*. These options are described below. To make a choice, you complete the Beneficiary Selection Form HCFA-382, sign it and return it to the facility supervising your care. You can get a copy of Form-382 from your dialysis facility. Once you make your initial choice, you must continue under that option until December 31 of that year. You can change from one method to the other by filing a new Form-382 at any time, but the change does not go into effect until the following January 1. It is important to remember that choosing *Method I* or *Method II* does not in any way prevent you from returning to treatment in a center, selecting another kind of treatment for ESRD care, or choosing to associate with another facility.

Method I: The Composite Rate

If you choose *Method I* your dialysis facility is responsible for providing all services, equipment and supplies necessary for home dialysis. Medicare pays the facility directly for these items and services at a pre-determined composite rate. Under this arrangement, you are responsible for paying the $75 deductible and the 20 percent coinsurance on the Medicare rate to the facility.

Method II: Dealing Directly with a Supplier

If you choose *Method II*, you must deal directly with a single supplier to obtain all of your home dialysis equipment and supplies. You must have only one supplier. Your supplier must have a written agreement with a dialysis facility to guarantee that you will receive all necessary backup and home dialysis support services. Your supplier must accept assignment of Medicare benefits (that is, the supplier must accept Medicare's allowance for its charges). If your supplier does not accept assignment, Medicare will not pay anything, and you will be responsible for the supplier's entire bill. If your supplier accepts assignment, you are responsible for any unmet part of the $100 deductible and for 20 percent coinsurance of the approved charges for these items and services. There is a national payment limit under *Method II*, and no supplier may charge more than this limit.

Under both methods, you must receive your home dialysis support services from your facility, for which Medicare pays the facility directly.

HOME DIALYSIS EQUIPMENT

Under *Method I*, all home dialysis equipment and equipment- related services are covered under the facility's composite rate payment. Under *Method II*, Part B also covers rental or purchase of dialysis equipment for home use. Delivery, installation and maintenance charges are included as part of this benefit.

Whether you rent or buy dialysis equipment, Part B usually makes monthly payments. If you buy dialysis equipment, the monthly Part B payment includes any reasonable interest or carrying charges that may be part of an

installment purchase agreement with the supplier of the equipment.

After the $100 deductible, Part B pays 80 percent of the approved monthly rental charge or the approved monthly installment purchase price for your home dialysis equipment.

Part B payments for your home dialysis equipment can continue as long as you need to be dialyzed at home. If your need for home dialysis stops, Part B payments also stop. For example, if you no longer need to be dialyzed because you have successful kidney transplant surgery, then Part B payments for your home dialysis equipment would usually stop.

If you stop using your home dialysis equipment temporarily—for example, because you are traveling or are hospitalized—Part B will continue its payments for the equipment for up to 3 months after the month in which you last used the equipment. If at a later date you use the equipment again, Part B payments would also start again.

Of course, if you purchase your dialysis equipment, Part B payments always stop when the purchase price approved as a basis for payments is reached.

HOME DIALYSIS SUPPLIES

Part B covers all supplies necessary to perform home dialysis. This includes disposable items such as alcohol wipes, sterile drapes and rubber gloves, forceps, scissors, and topical anesthetics. Under *Method I*, all home dialysis supplies are covered under the facility's composite rate payment. Under *Method II*, after the $100 deductible, Part B pays 80 percent of the approved charges for all covered items.

HOME DIALYSIS SUPPORT SERVICES

Part B covers periodic support services, furnished by an approved hospital or facility, which are necessary to help you remain on home dialysis. After your doctor approves the plan of treatment, such support services may include visits by trained hospital or facility personnel to periodically monitor your home dialysis and to assist in emergencies when necessary. Part B also covers the services of qualified facility or hospital personnel to inspect your dialysis equipment and to test your water supply.

Under *Method I*, all home dialysis support services are covered under the facility's composite rate payment. Under *Method II*, Part B pays directly to the facility 80 percent of the approved charges for all covered services after the $100 deductible has been met.

KIDNEY TRANSPLANT SURGERY

Both parts of Medicare help pay for kidney transplant surgery.

WHAT HOSPITAL INSURANCE (PART A) PAYS FOR

Medicare Part A covers your inpatient hospital services in an approved hospital when you are admitted for kidney transplant surgery. (See page 1 for more information about the Medicare inpatient hospital benefit.) Part A also covers hospital services in preparation for your kidney transplant. This includes the Kidney Registry fee and services such as laboratory and other tests that are required to evaluate your medical condition and the medical conditions of potential kidney donors. These preparatory services are covered whether they are done by the approved hospital where your transplant surgery will take place or by another hospital that participates in Medicare. If there is no kidney donor, the costs of obtaining a suitable kidney for your transplant surgery are also covered.

Part A pays the full cost of care for a person who donates a kidney for your transplant surgery. This includes all reasonable preparatory, operation, and post-operative recovery expenses connected with the donation. There is no deductible or daily amount for your donor's hospital stay. The inpatient hospital stay does not qualify your donor for any Medicare benefits not associated with the kidney donation. But, Medicare Part A will pay for any additional inpatient hospital care your donor might need if complications result directly from the kidney donation. Medicare does not pay for kidneys; the purchase of human organs is prohibited by law.

Medicare Part A payments are made directly to the hospital.

WHAT MEDICAL INSURANCE (PART B) PAYS FOR

Medicare Part B covers your surgeon's services for performing the kidney transplant operation. This includes pre-operative care, the surgical procedure, and follow-up care. Part B

also covers doctors services provided to your kidney donor during his or her inpatient hospital stay while you are receiving a kidney transplant.

After you meet the $100 Part B deductible, Part B pays 80 percent of the approved charge for your surgeon's services to you. There is no deductible or coinsurance for doctors services provided to your kidney donor; Medicare pays these services in full. Part B payments for your surgeon's services are paid for as explained in *The Medicare Handbook.*

Medicare pays for your immunosupressive drugs for a period of one year following your discharge from the transplant hospital. This benefit is subject to the Part B deductible and coinsurance provisions.

HOW MEDICARE PAYS FOR BLOOD

Both parts of Medicare can help pay for whole blood or units of packed red blood cells, blood components, and the cost of blood processing and administration.

If you receive blood as an inpatient of a hospital or skilled nursing facility, Part A can pay all of these blood costs, *except for any nonreplacement fees charged for the first three pints of whole blood or units of packed red cells each year.* The nonreplacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

You are responsible for the nonreplacement fees for the first three pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can arrange for another person or an organization to replace it for you. A hospital or skilled nursing facility cannot charge you for any of the first three pints of blood you have replaced or have arranged to replace.

If you have paid for or replaced some units of blood under Medicare Part B during the calendar year, you do not have to pay for or replace that number of units again under Part A.

Part B can help pay for blood and blood components you receive as an outpatient or as part of other covered services, *except for any nonreplacement fees charged for the first three pints or units received in each calendar year.* After you have met the $100 deductible, Part B pays 80 percent of the approved charges for blood starting with the fourth pint in a calendar year.

Medicare does not cover blood in connection with self-dialysis at home unless it is provided as part of a doctor's service or is needed solely for the purpose of priming the dialysis equipment.

If you have paid for or replaced blood under Medicare Part A during the calendar year, you do not have to do so again under Part B.

WHAT MEDICARE DOES NOT COVER

The following list shows some of the services and supplies that Medicare does not cover in connection with dialysis and transplant services. *The Medicare Handbook* lists other services and supplies which are not covered by Medicare (see "What Medicare does not cover").

- Ambulance or other transportation costs to a facility for routine outpatient maintenance dialysis
- Dialysis aides' services to assist in home dialysis
- Inpatient hospital and skilled nursing facility costs when the stay is solely for maintenance dialysis
- Lodging costs when an outpatient dialysis facility is not near your home
- Wage losses to you and your dialysis partner during self-dialysis training

OTHER PAYMENT SOURCES

If you have health care protection from private health insurance, the Veterans Administration, the Indian Health Service, a federal employee's health plan, CHAMPUS, or another source, it also may help pay for services you need for the treatment of permanent kidney failure.

In most states there are agencies that help with some of the medical expenses Medicare does not cover. Some states have Kidney Commissions that assist people in meeting the expenses Medicare cannot pay. And most states have a Medicaid program that helps pay medical expenses in cases of serious financial need.

Under certain circumstances, employer group health plans, including federal employee health plans, will be required to pay their benefits before Medicare pays (see page 2).

DIALYSIS PATIENTS WHO TRAVEL

If you are a dialysis patient and plan to travel, you should make arrangements for dialysis care along the route of your trip *before* you travel away from your usual dialysis facility. You are responsible for ensuring that an approved dialysis facility along the way has space and time available for your care, and that the physician and other medical personnel at the facility have enough information about you to treat you properly. Your facility will assist you in making the necessary inquiries.

When you plan your trip, take into account the location of Medicare approved dialysis facilities. There are over 1,800 facilities around the country. Your facility, dialysis network, or local kidney organization should be able to help you obtain the names and addresses of those facilities.

In general, Medicare will pay only for hospital or medical care received in the United States. An exception is made for services provided for emergency care given by qualified Canadian or Mexican hospitals. Please read *The Medicare Handbook* to find out about coverage of care received in Canadian and Mexican hospitals.

FOR ADDITIONAL HELP

If you have any questions about Medicare, contact your nearest Social Security office or the Medicare insurance carrier in your area. The carriers are listed in the back of The Medicare Handbook, which is available from the Social Security office.

OTHER PUBLICATIONS ABOUT MEDICARE

Guide to Health Insurance for People with Medicare (507-X)

Discusses what Medicare pays and does not pay, types of private health insurance to supplement Medicare and gives hints on shopping for private health insurance. (HCFA-02110)

Hospice Benefits Under Medicare (508-X)

Describes the scope of medical and support services available to Medicare beneficiaries with terminal illnesses. (HCFA-02154)

Medicare and Coordinated Care Plans (509-X)

Describes the health services available to beneficiariesfrom HMOs and CMPs. (HCFA-02195)

Getting a Second Opinion (536-X)

Explains the importance of getting a second opinion for non-emergency surgery, describes Medicare coverage of costs, and gives suggestions for locating a specialist in your area. (HCFA-02114)

Medicare and Employer Health Plans (586-X)

Explains the special rules that apply to Medicare beneficiaries who have employer group health plan coverage. (HCFA-02150)

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